STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155764	A. BUILDING 02 B. WING	03/07/2012

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SPRING MILL HEALTH CAMPUS	101 W 87TH AVE MERRILLVILLE, IN 46410

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PERCEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
K0000	A Life Safety Code Recertification and State Licensure Survey was conducted by the Indiana State Department of Health in accordance with 42 CFR 483.70(a). Survey Date: 03/07/12 Facility Number: 010739 Provider Number: 155674 AIM Number: N/A Surveyor: Bridget Brown, Life Safety Code Specialist At this Life Safety Code survey, Spring Mill Health Campus was found not in compliance with Requirements for Participation in Medicare/Medicaid, 42 CFR Subpart 483.70(a), Life Safety from Fire and the 2000 edition of the National Fire Protection Association (NFPA) 101, Life Safety Code (LSC), Chapter 18, New Health Care Occupancies and 410 IAC 16.2. This fully sprinklered facility was located on one wing on the first and second floors of a two story	K0000	The submission of this plan of correction does not indicate an admission by Spring Mill Health Campus that the findings and allegations contained herein are accurate and true representations of the quality of care and services provided to the residents of Spring Mill Health Campus . This facility recognized its obligation to provide legally and medically necessary care and services to its residents in an economic and efficient manner. The facility hereby maintains it is in substantial compliance with the requirements of participation for comprehensive health care facilities.(for Title 18/19 programs). To this end, this plan of correction shall serve as the credible allegation of compliance with all state and federal requirements governing the management of this facility. It is thus submitted as a matter of statue only .	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155764	A. BUILDING 02 B. WING	03/07/2012

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SPRING MILL HEALTH CAMPUS	101 W 87TH AVE MERRILLVILLE, IN 46410

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PERCEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	building, and the first floor of a 2007 wing addition determined to be of Type V (111) construction. The facility has a fire alarm system with smoke detection in all resident rooms, corridors and spaces open to the corridors. The facility has the capacity for 58 and had a census of 52 at the time of this survey. Quality Review by Robert Booher, Life Safety Code Specialist-Medical Surveyor on 03/13/12. The facility was found not in compliance with the aforementioned regulatory requirements as evidenced by:			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155764	A. BUILDING 02 B. WING	03/07/2012

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SPRING MILL HEALTH CAMPUS	101 W 87TH AVE MERRILLVILLE, IN 46410

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PERCEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
K0011 SS=E	NFPA 101 LIFE SAFETY CODE STANDARD If the building has a common wall with a nonconforming building, the common wall is a fire barrier having at least a two-hour fire resistance rating constructed of materials as required for the addition. Communicating openings occur only in corridors and are protected by approved self-closing fire doors. 18.1.1.4.1, 18.1.1.4.2 Based on observation and interview, the facility failed to ensure 1 of 2 door sets in the fire barrier separating health care from the assisted living occupancy provided the protection needed for a two hour fire barrier. This deficient practice could affect visitors, staff and 13 residents of the Rehab Unit. Findings include: Based on observation with the plant operations assistant on 03/07/12 at 3:00 p.m., the double door set installed in a two hour fire separation wall between the health care center and the assisted living dining room had no fire rating. The plant operations assistant acknowledged at the time of observation, it could not be ensured the doors provided the minimum protection required for a	K0011	1. The double door set between the assisted living dining room and the health care center will be replaced by June 20, 2012.2. The Plant Operations Director performed a facility-wide audit to confirm that there were no other fire barrier doors that do not meet the standard.3. Any new construction or remodeling that requires the installation of new fire barrier doors, will be first approved by the Plant Operations Director before their installation.4. Any deficiencies will be brought by the Plant Operations Director to the monthly QA Committee meeting on an on-going basis.We are requesting an extension of time for this K-tag because we have to use the services of an architect, then special order the doors, and then have the contractor complete the installation. It is anticipated that the timeline will be shorter than the date certain requested. With regards to fire safety awareness, while the non-compliance continues, the building is fully sprinkled, fire drills are routinely performed, and evacuation	05/31/2012

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155764	A. BUILDING 02 B. WING	03/07/2012

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SPRING MILL HEALTH CAMPUS	101 W 87TH AVE MERRILLVILLE, IN 46410

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PERCEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	two hour fire barrier. 3.1-19(b)		policies/procedures are current.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155764	A. BUILDING 02 B. WING	03/07/2012

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SPRING MILL HEALTH CAMPUS	101 W 87TH AVE MERRILLVILLE, IN 46410

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PERCEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
K0017 SS=E	NFPA 101 LIFE SAFETY CODE STANDARD Corridor walls form a barrier to limit the transfer of smoke. Such walls are permitted to terminate at the ceiling where the ceiling is constructed to limit the transfer of smoke. No fire resistance rating is required for the corridor walls. 18.3.6.1, 18.3.6.2, 18.3.6.5 Based on observation and interview, the facility failed to ensure corridor walls in 1 of 4 first floor smoke compartments formed a barrier to limit the transfer of smoke. This deficient practice could affect visitors, staff and 13 on the Rehab unit. Findings include: Based on observation with the plant operations assistant on 03/07/12 at 3:15 p.m., a six by ten inch metal vent opening was located in the wall between the clean linen storage room and the exit corridor serving the rehab unit. The plant operations assistant acknowledged at the time of observation, the wall would not resist the passage of smoke. 3.1-19(b)	K0017	1. The six by ten inch metal vent opening located in the wall between the clean linen storage room and the exit corridor serving the rehab unit has been removed and replaced with drywall.2. A survey of the building was conducted by the Plant Operations Director to ensure that no other vents and/or like openings exists between smoke compartments.3. Any new construction, or remodeling, that is planned will be reviewed by the Plant Operations Director to ensure that a breach will not exist between smoke compartments.4. Changes to any structure at the facility will be brought monthly on an on-going basis to the QA Committee meeting by the Plant Operations Director for review.	03/23/2012

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155764	A. BUILDING 02 B. WING	03/07/2012

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SPRING MILL HEALTH CAMPUS	101 W 87TH AVE MERRILLVILLE, IN 46410

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PERCEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
K0022 SS=E	NFPA 101 LIFE SAFETY CODE STANDARD Access to exits is marked by approved, readily visible signs in all cases where the exit or way to reach exit is not readily apparent to the occupants. 7.10.1.4 Based on observation and interview, the facility failed to ensure 1 of 7 Health Care 1 internally illuminated exit signs marking exit access was maintained. LSC 7.10.5.2 requires internally illuminated signs shall be provided with continuous illumination. This deficient practice affects visitors, staff and 17 residents on Health Care 1. Findings include: Based on observation with the plant operations assistant on 03/07/12 at 2:10 p.m., the exit light near room 1113 was not illuminated. The plant operations assistant said at the time of observation, two internal bulbs were both "out." 3.1-19(b)	K0022	1. The exit sign near room 1113 was replaced by the Plant Operations Director.2. An inspection of all illuminated exit signs was conducted by the Plant Operations Director to ensure proper functioning.3. The maintenance schedule was modified to include inspections of the exit signs.4. The Plant Operations Director will monitor the schedule to ensure compliance, and any deficiencies will be brought on an ongoing basis to the monthly QA Committee meeting.	03/08/2012

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155764	A. BUILDING 02 B. WING	03/07/2012

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SPRING MILL HEALTH CAMPUS	101 W 87TH AVE MERRILLVILLE, IN 46410

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PERCEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
K0034 SS=E	NFPA 101 LIFE SAFETY CODE STANDARD Stairways and smokeproof towers used as exits are in accordance with 7.2. 18.2.2.4 Based on observation and interview, the facility failed to ensure 2 of 2 exit stairways were separated from an enclosed usable space by the two hour fire resistance of the stairway exit enclosure. The exception to LSC 7.2.2.5.3 permits enclosed usable space under stairs, provided that the space is separated from the stair enclosure by the same fire resistance as the stair enclosure. Entrance to such enclosed usable space shall not be from within the stair enclosure. This deficient practice affects visitors, staff and 39 residents on the second floor and Health Care 1. Findings include: Based on observation with the plant operations assistant on 03/07/12 between 11:45 a.m. and 3:45 p.m., spaces under both exit stairways on the first floor were used for storage. The Health Care 1 stairway by the elevator had a dresser, night stand, mirror, and folded table under it and the north	K0034	1. All furniture was removed from under the stairway on Health Care 1 by the elevator, and the rolls of carpet were removed from under the stairway on north Health Care 1 by the Plant Operations Assistant.2. An inspection of the other stairways at the facility was conducted to ensure that nothing was being stored under them.3. Stairway inspections have been added to the maintenance schedule.4. Any deficiencies noted by the Plant Operations Director will be brought on an ongoing basis to the monthly QA Committee meeting.	03/23/2012

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155764	A. BUILDING 02 B. WING	03/07/2012

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SPRING MILL HEALTH CAMPUS	101 W 87TH AVE MERRILLVILLE, IN 46410

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PERCEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	Health Care 1 stairway held two commercial sized rolls of carpet. The plant operations assistant acknowledged at the time of observations, the stairway enclosure was not for storage. 3.1-19(b)			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155764	A. BUILDING 02 B. WING	03/07/2012

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SPRING MILL HEALTH CAMPUS	101 W 87TH AVE MERRILLVILLE, IN 46410

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PERCEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
K0038 SS=E	NFPA 101 LIFE SAFETY CODE STANDARD Exit access is arranged so that exits are readily accessible at all times in accordance with section 7.1. 18.2.1 Based on observation and interview, the facility failed to ensure egress for 1 of 3 Rehab Unit exits was arranged to be accessible. LSC 7.1.3.2.3 requires that an exit enclosure shall not be used for any purpose with the potential to interfere with its use as an exit. LSC 7.1.10.1 "Means of egress shall be continuously free of all obstructions or impediments to full instant use in case of fire or other emergency use." This deficient practice affects visitors, staff and 13 residents on the Rehab Unit. Findings include: Based on observation with the plant operations assistant on 03/07/12 at 1:20 p.m., the egress path for the Rehab Unit through the service corridor was used as a collection point for deliveries. The corridor was congested with 12 cardboard cartons and a pallet jack. The equipment and cartons remained in the egress path when	K0038	1. All of the cartons and the pallet jack were removed from the service corridor and stored in their appropriate areas.2. The Plant Operations Director inspected the remainder of the facility to see if any of the other service corridors had similar issues.3. The Plant Operations Director will make daily rounds to ensure that corridors remain free of obstructions.4. Any deficiencies will be brought on an ongoing basis to the monthly QA meeting by the Plant Operations Director.	03/07/2012

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155764	A. BUILDING 02 B. WING	03/07/2012

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SPRING MILL HEALTH CAMPUS	101 W 87TH AVE MERRILLVILLE, IN 46410

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PERCEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	observed again with the plant operations assistant on 03/07/12 at 2:20 p.m. The plant operations assistant acknowledged at the time of observations, the exit path was diminished to less than three feet by the items left there and staff would waste time clearing the halls if the fire alarm sounded for an emergency. 3.1-(19)			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155764	A. BUILDING 02 B. WING	03/07/2012

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SPRING MILL HEALTH CAMPUS	101 W 87TH AVE MERRILLVILLE, IN 46410

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PERCEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
K0044 SS=E	NFPA 101 LIFE SAFETY CODE STANDARD Horizontal exits, if used, are in accordance with 7.2.4. 18.2.2.5 Based on observation and interview, the facility failed to ensure 1 of 2 door sets in fire barriers between the assisted living and healthcare occupancies would close and latch. LSC 7.2.4.3.8 requires fire barrier doors to be self closing or automatic closing in accordance with 7.2.1.8. NFPA 80, the Standard for fire Doors and Fire Windows at 2-4.1.4 requires all closing mechanisms shall be adjusted to overcome the resistance of the latch mechanism so positive latching is achieved on each door operation. NFPA 80, 1-9.2 requires builders hardware such as latches on fire doors. This deficient practice affects visitors, staff, and 13 residents on the Rehab Unit. Findings include: Based on observation with the plant operations assistant on 03/07/12 at 3:00 p.m., the double door set in the fire wall separating the assisted living	K0044	1. The double door set in the fire wall separating the assisted living dining room and the Health Care exit corridor for the Rehab unit will be replaced to assure that positive latching is obtained.2. The plant Operations Director performed a facility-wide audit of all the fire barrier doors to assure that the latches were functioning properly.3. The Plant Operations Director has modified the maintenance schedule to ensure that all of the doors are regularly checked.4. Any deficiencies will be brought on an ongoing basis to the monthly QA Committee meeting by the Plant Operations Director. We are requesting an extension of time for this K-tag because we have to use the services of an architect, then special order the doors, and then have the contractor complete the installation. It is anticipated that the timeline will be shorter than the date certain requested. This K-tag is associated with K-0011.With regards to fire safety awareness, while the non-compliance continues, the building is fully sprinkled, fire drills are routinely performed, and evacuation policies/procedures are current.	05/31/2012

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155764	A. BUILDING 02 B. WING	03/07/2012

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SPRING MILL HEALTH CAMPUS	101 W 87TH AVE MERRILLVILLE, IN 46410

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PERCEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	dining room and a Health Care exit corridor for the Rehab Unit had no latch. The plant operations assistant agreed at the time of observation, doors in a fire barrier should latch. 3.1-19(b)			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155764	A. BUILDING 02 B. WING	03/07/2012

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SPRING MILL HEALTH CAMPUS	101 W 87TH AVE MERRILLVILLE, IN 46410

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PERCEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
K0048 SS=F	NFPA 101 LIFE SAFETY CODE STANDARD There is a written plan for the protection of all patients and for their evacuation in the event of an emergency. 18.7.1.1 Based on record review and interview, the facility failed to include the use of the K class extinguisher and evacuation of a smoke compartment in the written fire plan for the protection of 52 of 52 residents in the event of an emergency. LSC 19.7.2.2 requires a written health care occupancy fire safety plan shall provide for the following: (1) Use of alarms (2) Transmission of alarm to the fire department (3) Response to alarms (4) Isolation of fire (5) Evacuation of immediate area (6) Evacuation of smoke compartment (7) Preparation of floors and building for evacuation (8) Extinguishment of fire This deficient practice could affect all occupants. Findings include: Based on review of five pages provided as evidence of policy and	K0048	1. The page titled Fighting a Fire from the Fire Safety Preparedness - Operational Procedure (A-4) was modified by the Plant Operations Director to include the use of a K-class fire extinguisher in conjunction with the kitchen fire extinguisher system, The page titled Discovering a Minor Fire (A-2) was modified to include instructing the staff to activate the alarm and to evacuate from one smoke compartment to another.2. The Plant Operations Director audited the rest of the facility emergency manuals to ensure that they were current. The procedures were modified as necessary.3. All changes to the emergency manuals will be approved by the Plant Operations Director and the Executive Director.4. Any discrepancies will be brought on an ongoing basis to the monthly QA Committee meeting by the Plant Operations Director.	03/16/2012

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155764	A. BUILDING 02 B. WING	03/07/2012

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SPRING MILL HEALTH CAMPUS	101 W 87TH AVE MERRILLVILLE, IN 46410

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PERCEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	procedures for fire safety with the plant operations assistant on 03/07/12 at 12:45 p.m., a page titled Fighting A Fire from the Fire Safety Preparedness -Operational Procedures (A-4) instructed staff to "immediately begin fire fighting procedures" when a fire was discovered and directed use of ABC fire extinguishers. "Our office uses only ABC extinguishers." No mention of the K class extinguisher in conjunction with the kitchen fire extinguishing system was included. Page A-2 titled Discovering a Minor Fire instructed staff to extinguish a minor fire and "Do not evacuate unless it is necessary." There was no instruction to activate an alarm and no page included evacuation from one smoke compartment to another. The plant operations assistant acknowledged at the time of record review, the plan did not have all required elements. 3.1-19(b)			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155764	A. BUILDING 02 B. WING	03/07/2012

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SPRING MILL HEALTH CAMPUS	101 W 87TH AVE MERRILLVILLE, IN 46410

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PERCEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
K0051 SS=E	NFPA 101 LIFE SAFETY CODE STANDARD A fire alarm system with approved components, devices or equipment is installed according to NFPA 72, to provide effective warning of fire in any part of the building. Activation of the complete fire alarm system is by manual fire alarm initiation, automatic detection, or extinguishing system operation. Pull stations are located in the path of egress. Electronic or written records of tests are available. A reliable second source of power is provided. Fire alarm systems are maintained in accordance with NFPA 72, National Fire Alarm Code, and records of maintenance are kept readily available. There is remote annunciation of the fire alarm system to an approved central station. 18.3.4, 9.6 1. Based on observation and interview, the facility failed to ensure 1 of 3 fire alarm panels in an area not continuously occupied was provided with automatic smoke detection to ensure notification of a fire at the location before it could be incapacitated by fire. LSC 9.6.2.10.1 requires smoke alarms shall be in accordance with NFPA 72, National Fire Alarm Code. NFPA 72, 1-5.6 requires an automatic smoke detector be provided at the location of each fire alarm control unit which is not located in an area continuously occupied to provide notification of a fire in	K0051	1. (a.) A smoke detector was installed into the fire alarm system where the adjunct fire alarm control panel is located in the first floor foyer entry of the Health Center. (b.) The smoke detector in the janitor's office was relocated away from the air vent.2. The Plant Operations Director performed an audit of the facility to make certain that all fire alarm panels are in areas that are continuously occupied or supervised electronically. The Plant Operations Director conducted a facility-wide audit of all smoke detectors to assure that they were not located where airflow would pose a problem to the proper functioning of the device.3. Any new construction or remodeling that includes fire alarm panels or mounting/relocation of smoke	03/23/2012

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155764	A. BUILDING 02 B. WING	03/07/2012

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SPRING MILL HEALTH CAMPUS	101 W 87TH AVE MERRILLVILLE, IN 46410

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PERCEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	that location. This deficient practice affects all occupants. Findings include: Based on observation with the plant operations assistant on 03/07/12 at 2:10 p.m., an adjunct fire alarm control panel (FACP) was located in a first floor entry foyer of the health center. The plant operations assistant acknowledged at the time of observation, the area was not continuously occupied. The area was not electrically supervised by a smoke detector. 3.1-19(b) 2. Based on observation and interview, the facility failed to ensure a smoke detector connected to the fire alarm system in 1 of 2 second floor smoke compartments, was properly separated from an air supply. NFPA 72, 2-3.5.1 requires, in spaces served by air handling systems, detectors shall not be located where airflow prevents operation of the detectors. This deficient practice could affect		detectors, will be supervised and approved by the Plant Operations Director.4. Any deficiencies will be brought on an ongoing basis to the monthly QA Committee meeting by the Plant Operations Director.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155764	A. BUILDING 02 B. WING	03/07/2012

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SPRING MILL HEALTH CAMPUS	101 W 87TH AVE MERRILLVILLE, IN 46410

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PERCEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	visitors, staff, and 22 or more residents in the north Health Care smoke compartment. Findings include: Based on observation with the plant operations assistant on 03/07/12 at 4:25 p.m., the janitors closet smoke detector was located 18 inches from an air vent. The plant operations assistant confirmed the distance measurement and acknowledged at the time of observation, air flow could impede the function of the smoke detector. 3.1-19(b)			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155764	A. BUILDING 02 B. WING	03/07/2012

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SPRING MILL HEALTH CAMPUS	101 W 87TH AVE MERRILLVILLE, IN 46410

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PERCEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
K0056 SS=E	NFPA 101 LIFE SAFETY CODE STANDARD There is an automatic sprinkler system, installed in accordance with NFPA 13, Standard for the Installation of Sprinkler Systems, with approved components, devices, and equipment, to provide complete coverage of all portions of the facility. The system is maintained in accordance with NFPA 25, Standard for the Inspection, Testing, and Maintenance of Water-Based Fire Protection Systems. There is a reliable, adequate water supply for the system. The system is equipped with waterflow and tamper switches which are connected to the fire alarm system. 18.3.5. Based on observation and interview, the facility failed to provide complete sprinkler coverage for all areas in 1 of 4 first floor smoke compartments. LSC 19.1.6.2 requires facilities of Type V (111) construction be provided with complete sprinkler protection. This deficient practice affects visitors, staff, and 17 residents on Health Care 1. Findings include: Based on observation with the plant operations assistant on 03/07/12 at 1:05 p.m., three wall partitions in the Health Care 1 spa created three spaces which were not protected by two sprinklers in	K0056	1. Additional sprinklers were added to the Health Care 1 spa to give coverage to the areas that were partitioned off.2. The Plant Operations Director inspected the rest of the facility for areas that might not be adequately covered by sprinklers. None was found.3. Any new construction or remodeling that is conducted at the facility will be approved by the Plant Operations Director.4. Any deficiencies that are noted will be brought on an ongoing basis to the monthly QA Committee meeting.	03/23/2012

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155764	A. BUILDING 02 B. WING	03/07/2012

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SPRING MILL HEALTH CAMPUS	101 W 87TH AVE MERRILLVILLE, IN 46410

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PERCEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	the spa. The plant operations assistant agreed at the time of observation, sprinkler protection was blocked by the tiled wall partitions. 3.1-19(b)			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155764	A. BUILDING 02 B. WING	03/07/2012

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SPRING MILL HEALTH CAMPUS	101 W 87TH AVE MERRILLVILLE, IN 46410

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PERCEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
K0062 SS=F	NFPA 101 LIFE SAFETY CODE STANDARD Required automatic sprinkler systems are continuously maintained in reliable operating condition and are inspected and tested periodically. 18.7.6, 4.6.12, NFPA 13, NFPA 25, 9.7.5 Based on record review and interview, the facility failed to ensure a weekly test to check water flow conditions for 1 of 1 fire pumps was conducted. NFPA 25, the Standard for the Inspection, Testing and Maintenance of Water-Based Fire Protection Systems 5-3.2.1 requires a weekly test of electric motor driven pump assemblies shall be conducted without flowing water. This test shall be conducted by starting the pump automatically. The pump shall run a minimum of 10 minutes. This deficient practice could affect all occupants. Findings include: Based on review of maintenance records and the Reports of Inspection for the inspection, testing and maintenance of the sprinkler system with the plant operations assistant on 03/07/12	K0062	1. The fire pump test was successfully conducted by the Plant Operations Director on March 19, 2012.2. No other fire pumps exist at the facility.3. The weekly fire pump test has been added to the maintenance schedule.4. Any deficiencies will be brought on an ongoing basis to the monthly QA Committee by the Plant Operations Director.	03/19/2012

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155764	A. BUILDING 02 B. WING	03/07/2012

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SPRING MILL HEALTH CAMPUS	101 W 87TH AVE MERRILLVILLE, IN 46410

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PERCEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	at 12:10 p.m., a fire pump test was conducted by the sprinkler system contractor on 03/23/11. A record of weekly tests of the fire pump was not found. The plant operations assistant said at the time of record review, there was no record and he did not know the test was required. 3.1-19(b)			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155764	A. BUILDING 02 B. WING	03/07/2012

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SPRING MILL HEALTH CAMPUS	101 W 87TH AVE MERRILLVILLE, IN 46410

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PERCEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
K0143 SS=E	NFPA 101 LIFE SAFETY CODE STANDARD Transferring of oxygen is: (a) separated from any portion of a facility wherein patients are housed, examined, or treated by a separation of a fire barrier of 1-hour fire-resistive construction; (b) in an area that is mechanically ventilated, sprinklered, and has ceramic or concrete flooring; and (c) in an area posted with signs indicating that transferring is occurring, and that smoking in the immediate area is not permitted in accordance with NFPA 99 and the Compressed Gas Association. 8.6.2.5.2 Based on observation and interview, the facility failed to ensure 1 of 1 electrical switches in the oxygen storage room was located at least five feet above the floor. NFPA 99, 1999 Edition Standard for Health Care Facilities, Section 8-3.1.11.2(f) requires electrical fixtures in oxygen storage locations shall meet 4-3.1.1.2(a)11(d) which requires ordinary electrical wall fixtures in supply rooms shall be installed in fixed locations not less than five feet above the floor to avoid physical damage. This deficient practice could affect staff, visitors, and 6 residents in the vicinity of the oxygen storage room.	K0143	1. The light switch in the oxygen room has been moved upward on the wall so that it now meets the minimum allowable height of 60 inches.2. The Plant Operations Director conducted an inspection of all light switches at the facility to ensure that minimum guidelines for height has been observed.3. Any new or relocated switches will be approved by the Plant Operations Director.4. Any deficiencies noted by the Plant Operations Director will be brought on an ongoing basis to the monthly QA Committee meeting.	03/23/2012

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155764	A. BUILDING 02 B. WING	03/07/2012

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SPRING MILL HEALTH CAMPUS	101 W 87TH AVE MERRILLVILLE, IN 46410

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PERCEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	Findings include: Based on observation with the plant operations assistant on 03/07/12 at 4:20 p.m., a light switch was located 48 inches above the floor in the oxygen storage room identified by signage as an oxygen transfer room. The plant operations assistant said at the time of observation, he was unaware the minimum allowable height for the switch was 60 inches. 3.1-19(b)			